STATE OF CONNECTICUT – INSURANCE DEPARTMENT
REQUEST FOR EXTERNAL APPEAL
Return to:

• P.O. Box 816 • Hartford, CT 06142-0816
• 153 Market Street • Hartford, CT 06103 (OVERNIGHT MAIL ONLY)
•(860) 297-3910

ENROLLEE INFORMATION

Enrollee Name: _____ Patient Name: _____

Address: _____

_____

Enrollee Phone # :Home ( ) _____ Work ( ) _____

Enrollee Insurance ID #: _____

Insurance Claim/Reference #: _____

PROVIDER INFORMATION

Health Care Provider: _____

Address: _____

_____

Contact Person: _____ Phone: ( ) _____

Medical Record #: _____

MANAGED CARE ORGANIZATION

Managed Care Organization: _____

Address: _____

_____

Contact Person: _____ Phone: ( ) _____

UTILIZATION REVIEW COMPANY (If different than the Managed Care Organization)

Utilization Review Company: _____

Address: _____

_____

Contact Person: _____ Phone: ( ) _____

DESCRIBE IN DETAIL THE DISAGREEMENT WITH THE MANAGED CARE ORGANIZATION AND/OR UTILIZATION REVIEW COMPANY. INDICATE CLEARLY THE SERVICE(S) BEING DENIED AND THE SPECIFIC DATE(S) BEING DENIED. ATTACH ADDITIONAL PAGES IF NECESSARY AND INCLUDE PERTINENT MEDICAL RECORDS, IF AVAILABLE.

******* PLEASE COMPLETE BOTH SIDES OF THIS FORM ***** rev 11/03**

Enrollee Name: _____Enrollee Insurance ID #: _____

PLEASE CHECK BELOW (NOTE: YOUR REQUEST WILL NOT BE ACCEPTED FOR FULL REVIEW UNLESS ALL ITEMS BELOW ARE INCLUDED)

[ ] **YES**, I have included a photocopy of my insurance identification card;

[ ] **YES**, I have exhausted all internal appeal procedures with my Managed Care Organization/Utilization Review Company, and I have enclosed copies of all of the correspondence regarding the denial of the above mentioned service(s);

[ ] **YES**, I have enclosed a copy of my entire insurance policy benefit handbook or certificate of coverage, which defines all benefits and provisions with my Managed Care Organization;

[} **YES**, I have enclosed a **NON-REFUNDABLE** check or money order for $25 (Make checks payable to: Treasurer-State of Connecticut). (The filing fee will be waived for indigent individuals. Please see below, "Waiver of Filing Fee");

[ ] **YES**, I have executed the release of medical records (Please see below).

REQUEST FOR EXTERNAL APPEAL AND RELEASE OF MEDICAL RECORDS

I, _____ hereby request an external appeal and authorize the release of medical records necessary for the external review. I understand that these records may be obtained from the Managed Care Organization, the Utilization Review Company, the insurer and/or any relevant medical provider(s) and will be utilized solely for the purpose of conducting this external review and may be viewed by an auditor of the Insurance Department for quality surveillance and examination of record purposes. I understand that the decision of the external appeal entity is binding and that neither the Commissioner nor the external appeal entity may authorize services in excess of those covered by my health care plan.

_____

Signature of Patient (or Legal Representative)* Date
(*Parent, Guardian, Conservator, or Other – Please Specify)

_____

Signature of Provider Date
(The provider may request an external appeal with consent of the enrollee. The enrollee must execute the release of medical records.)

WAIVER OF FILING FEE

The $25 fee will be waived for indigent individuals or those who are unable to pay. Refer to Table 1 in the External Appeal Consumer Guide to determine if you qualify as indigent.

I hereby certify that I am indigent or that I am not able to pay and request a waiver of the filing fee.

_____

Signature of Enrollee (or Legal Representative) Date

****** PLEASE COMPLETE BOTH SIDES OF THIS FORM ******

FOR OFFICE USE ONLY

Date Received: _____/_____/_____ Assigned:_____/_____/_____

Vendor #: _____ Fee Received _____ Fee Waived _____ Initials: _____

Utilization Review Company: _____ Lic. #: _____